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Report to the Chairman, Subcommittee on Intergovernmental Relations and Human Resources, House Committee on Government Operations

December 1985

DISABILITY PROGRAMS

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SSA Consultative Medical Examination Process Improved; Some Problems Remain

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United States
General Accounting Office
Washington, D.C. 20548

Comptroller General
of the United States

B-217398

December 10, 1985

The Honorable Ted Weiss
Chairman, Subcommittee on Intergovernmental
Relations and Human Resources
Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

This report presents the results of our review of the Social Security Administration's (SSA's) management of the consultative medical examination process in SSA disability programs. Our review covered SSA and state disability agencies' activities from July 1982 to March 1985. Significant events occurring since March 1985 are also noted as appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its date of publication. At that time, we will send copies of the report to interested congressional committees, the Secretary of Health and Human Services, the Office of Management and Budget, the Commissioner of SSA, and other interested parties, and will make copies available to others upon request.

Sincerely yours,

Charles A. Bowsher

Comptroller General
of the United States

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Executive Summary

In fiscal year 1986, the Social Security Administration (SSA) will spend about $203 million on medical examinations of claimants seeking benefits under the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. These "consultative examinations" are purchased from private medical sources when sufficient evidence of medical impairment is unavailable from claimants' treating physicians. Consultative examinations often play a key role in determining benefit eligibility.

In 1981, improprieties in the examination and reporting procedures used by several volume providers of consultative examinations were alleged in court actions. At the same time, SSA began to review the eligibility of most beneficiaries, as mandated by the 1980 Disability Amendments. It terminated benefits for a large number of people. Since in many cases, consultative examinations were the only new medical evidence used to support terminations, concern about them became widespread. The Chairman of the House Subcommittee on Intergovernmental Relations and Human Resources asked GAO to

- evaluate how SSA manages the consultative examination process to ensure the quality and reliability of examinations and reports,
- evaluate SSA's controls to assure the necessity and appropriateness of consultative examination purchases, and
- identify and report on the operations of major volume providers nationwide.

Background

SSDI and SSI pay benefits to individuals who cannot work due to medically determinable physical or mental impairments. In 1984, these programs paid more than $25 billion to 6.3 million disabled individuals and their dependents.

Disability determinations are made by state agencies regulated by SSA. SSA permits states wide latitude in managing their agencies and exercises oversight through its regional offices. In 1976, consultative examinations were purchased for about 24 percent of claims processed; in 1984, for about 44 percent. The increase resulted from greater SSA emphasis on decisional accuracy and from the disability reexaminations, which require more consultative evidence to document the current severity of impairments.

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In assessing SSA's management of the consultative examination process, GAO focused on SSA management initiatives implemented since 1981. Visits were made to all 10 SSA regional offices, 7 state agencies, and 11 volume providers. Questionnaire responses from all state agencies and 96 volume providers were analyzed.

Results in Brief

Despite progress in improving the process, SSA still lacks reasonable assurance that good quality medical examinations and reports are obtained and the purchase of unnecessary examinations is prevented.

GAO identified 108 volume providers (those who earned more than $100,000 for performing consultative examinations in 1983) nationwide. They ranged from individual physicians, clinics, and hospitals to group practices devoted largely or exclusively to performing such examinations. About half of the states use volume providers, which perform about 26 percent of these states' examinations.

Principal Findings

In 1982, SSA required all state agencies to develop and implement management plans covering seven "critical elements" of the consultative examination process, including appointment scheduling and review of examination report quality.

Increased Monitoring of Providers

Through a questionnaire survey and visits to seven states, GAO found that state agencies have increased their monitoring of consultative examination providers.

Specific Guidance Lacking

But SSA did not specify how state agencies were to structure their management systems to control the critical elements of the consultative examination process. Over half of the state management plans did not adequately describe the agencies' procedures for preventing overscheduling of examinations or for conducting ongoing review of examination reports to ensure that deficient reports were identified and corrective actions taken. In visiting state agencies, GAO found that some lacked effective controls to ensure that SSA's objectives were met.

SSA Regional Oversight

SSA regional offices approve state management plans, review their implementation, and conduct annual comprehensive reviews of state agencies' management of the consultative examination process. At the

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time of GAO's visits, four regions had not reviewed their states' plan implementation, and one had reviewed plan implementation by only some of its states. Only one region had performed reviews comprehensive enough to include fiscal controls over purchasing of consultative examinations. Some states were not performing such monitoring activities as conducting on-site visits to volume providers or obtaining claimants' reactions to being examined by volume providers, as required by SSA.

Some Unnecessary Examinations

Between 8 and 23 percent of consultative examinations purchased were either unnecessary or of a wrong type, it was found in studies conducted by SSA regional office and state agency staff in four states. From 10 to 28 percent might not have been needed had more effort been made to obtain evidence from claimants' treating sources. One study also found that 60 percent of X-ray and 46 percent of diagnostic laboratory test purchases were unnecessary. SSA has not determined how large a problem unnecessary purchasing may be nationwide nor if additional controls such as more physician involvement in consultative examination ordering is needed to prevent unnecessary purchases.

Recommendations

To ensure that the consultative examination process is consistently managed nationwide and reduce SSA's vulnerability to the purchase of unnecessary examinations, GAO recommends that the Secretary of Health and Human Services direct the Commissioner of Social Security to

- require states that use volume providers to establish standards for controlling appointment scheduling and/or examination duration,
- provide more specific direction to states on structuring systems for reviewing examination reports,
- require SSA regional offices to reevaluate state agencies' consultative examination management plans,
- issue a comprehensive review guide to SSA regional offices for use in conducting annual and uniform comprehensive reviews of states' consultative examination management activities, and
- determine what controls are needed to minimize unnecessary purchases.

Agency Comments

GAO did not obtain written comments on this report from the Department of Health and Human Services. The matters covered in the report

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were, however, discussed with responsible SSA program officials. Their comments are incorporated where appropriate.

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Abbreviations

CDR	continuing disability review
CE	consultative examination
CEMS	Cost Effectiveness Measurement System
DDS	disability determination service
FAL	Fiscal and Administrative Letter
FAMR	Fiscal and Administrative Management Review
FAR	Federal Acquisition Regulations
FBI	Federal Bureau of Investigation
GAO	General Accounting Office
HHS	Department of Health and Human Services
OIG	Office of Inspector General
OMB	Office of Management and Budget
QA	quality assurance
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

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Chapter 1

Introduction

The Social Security Administration (SSA), under the Department of Health and Human Services, administers two national disability programs—Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). SSDI, authorized under title II of the Social Security Act, provides benefits to insured disabled workers and their families in amounts determined by the workers' wage history. SSI, authorized under title XVI of the Social Security Act, provides assistance to needy aged, blind, and disabled persons, many of whom lack recent work experience. In 1984, the two programs combined paid over $25 billion to about 6.3 million disabled individuals and their families.

Under SSDI and SSI, disability is defined as the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment expected to last at least 12 months or result in death. Generally, taking into account age, education, and work experience, beneficiaries must be unable to do any work that exists in the national economy.

SSA regulates and monitors the disability programs. Program policy, regulations, adjudicative criteria, and instructions are developed by SSA's central office in Baltimore, Maryland. Claimants apply for benefits at social security local offices nationwide.

Disability decisions, however, are made by 52 state[1] agencies (including those in the District of Columbia and Puerto Rico) known as disability determination services (DDSs), which are regulated by SSA. The DDSs develop medical evidence of the severity of claimants' impairments and make decisions based on medical, educational, and vocational factors. Staff in SSA's 10 regional offices monitor DDS operations.

SSA publishes adjudicative criteria, which define various impairments and provide a framework for assessing their impact on claimants' ability to work, in regulations, rulings, and other policy guidelines such as the Program Operations Manual System. SSA regulations establish specific case processing time and decisional accuracy standards, which DDSs are expected to meet. While adjudicative criteria and case processing standards are precisely defined, SSA permits states wide managerial flexibility in managing their agencies. The states are reimbursed 100 percent of

[1]Nationwide, there are 55 agencies and offices responsible for making disability determinations. However, three of these offices—those in the Virgin Islands, Guam, and the Northern Mariana Islands—were not considered in this review because they are small and are directly managed by SSA.

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the cost of making disability determinations—about $647 million in fiscal year 1984.

Medical Evidence and the Disability Determination Process

Through the disability determination process, the impact of physical and mental impairments on claimants' ability to work is evaluated. Decision-making involves

- medical and occupational evidence,
- SSA policy and criteria to evaluate the evidence, and
- individual judgment of adjudicators.

In making disability determinations, adjudicators are required to evaluate all pertinent facts by following a sequential evaluation process. This is a series of assessments of current work activity, severity of impairment, and such vocational factors as claimants' education and work experience. SSA regulations define the medical and vocational factors to be considered. If, at any step in the sequential evaluation process, eligibility can be determined, evaluation under subsequent steps is unnecessary. Thus, determinations can be based on medical factors alone or on a combination of medical and vocational factors. (See figure 1.1.)

The Social Security Act requires that disabling physical or mental impairments be demonstrated by "medically acceptable clinical and laboratory diagnostic techniques." Claimants' treating sources—physicians, clinics, or hospitals—are the preferred sources of evidence of impairment. SSA guidelines require DDSs to contact potential beneficiaries' treating sources for "medical evidence of record" unless a source is known to be unresponsive or unreliable. If a claimant's treating source is unavailable or cannot or will not provide sufficient evidence of impairment, the DDS must purchase an independent medical examination—a consultative examination (CE).

In 1984, treating-source information was obtained for about 62 percent of the 1.9 million initial disability claims processed, while CEs were purchased for about 50 percent of initial claims.

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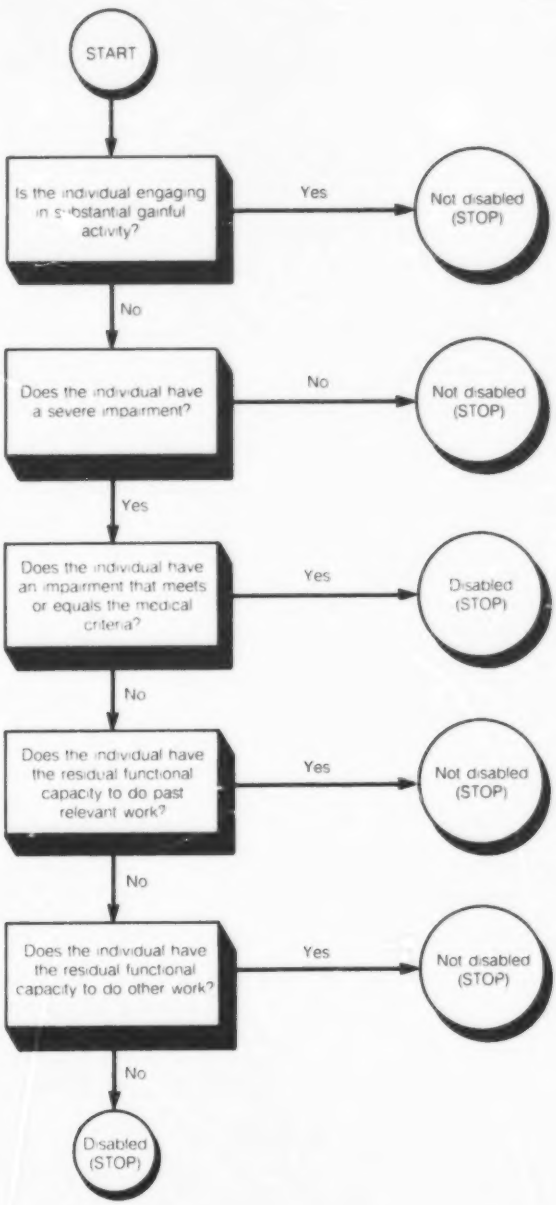
Figure 1.1: The Sequential Evaluation Process



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Use of Consultative Examinations Increasing

SSA guidelines stipulate that CEs may be purchased to

- clarify medical findings and diagnoses,
- obtain highly technical or specialized medical data not otherwise available,
- resolve a material conflict or inconsistency in the evidence, or
- resolve the issue of current severity in continuing disability cases.

CEs range from limited supplemental laboratory tests (e.g., blood tests, X-rays, or electrocardiograms) to full-scale physical or mental examinations, depending on the extent of evidence available from claimants' treating sources. The CE provider submits a report on the findings of its examination or test to the DDS.

CEs are purchased from private medical sources—individual physicians, group medical practices, clinics, or hospitals— recruited to serve on state "CE panels." Panel size varies widely among states. For example, in 1983, the California DDS listed 5,247 CE panelists, while the District of Columbia DDS had 100 CE panelists. States set the reimbursement for performing CEs; it generally is tied to the reimbursement rates other state agencies (e.g., vocational rehabilitation) use for the same services. In most states, physicians' charges are reimbursed up to a maximum level specified by the state's fee schedule.

DDS examiners, assisted by DDS physician staff, determine disability, drawing on CE reports and other medical and vocational evidence. The use of CEs in making disability decisions has increased. In fiscal year 1976, CEs were purchased for about 24 percent of claims processed; in fiscal year 1983, the rate increased to more than 42 percent. Total federal expenditures for CEs during the same period rose from $56 to $175 million.[2]

This increased rate of CE purchasing and total CE expenditures resulted from such factors as

- increased SSA claims documentation requirements,
- increased SSA emphasis on decisional accuracy, and

[2]Between July 1983 and March 1984, 18 states rebelled against SSA's disability criteria and imposed moratoria on processing continuing disability reviews (CDRs). In April 1984, SSA declared a nationwide moratorium on CDRs pending action on the proposed 1984 Disability Reform Act. Due to these widespread moratoria, CE expenditures in fiscal year 1984 declined to $157 million even though the CE purchase rate rose to 44 percent of claims processed. SSA officials said fiscal year 1984's expenditures are not representative of normal operations and should not be used for comparative purposes.

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- continuing investigations, required by the 1980 Disability Amendments, of persons already receiving disability benefits.

As demand for CEs grew, many DDSs began to purchase them from "volume providers," physicians or medical practices devoted largely or exclusively to performing CEs. Typically, these sources do a large number of CEs and provide examination reports expeditiously on a continuing basis.

The increasing use of CEs and volume providers in the disability programs stimulated a corresponding increase in concern about the CE process. At 1981 congressional hearings, questions were raised about the thoroughness of examinations done by volume providers, the reliability of their reports, and the effectiveness of SSA and DDS management and oversight of the CE process.

Concern about SSA's disability decision process—including the use and quality of CEs—was heightened when SSA and the state agencies began carrying out the legislative mandate to review the eligibility of those already on the disability rolls. From March 1981 to June 1984, the eligibility of 1.2 million beneficiaries was reviewed. Benefits were terminated in about 500,000 cases, 41 percent of the cases reviewed. The large number of terminations brought about more congressional hearings, federal court cases, and the moratoria by some states on processing CDRs and led to enactment in October 1984 of the Social Security Disability Benefits Reform Act of 1984.

This act, which SSA is now in the process of developing regulations to implement, establishes medical improvement standards for continuing disability reviews. Among its many other provisions, it also requires SSA to prescribe standards for deciding when and what type of CEs should be obtained and procedures for monitoring the CE process.

Objectives, Scope, and Methodology

In July 1983, the Chairman of the Intergovernmental Relations and Human Resources Subcommittee, House Committee on Government Operations, asked us to review the CE process and certain volume providers. Posed in the request were nine questions, ranging in subject from the impact of CEs on benefit terminations to specific information on the operations of four volume providers. After discussions with the Chairman's office, the scope of the investigation was changed somewhat and we agreed to

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- evaluate SSA and state efforts to manage the CE process so as to ensure the quality and reliability of examinations and reports;
- evaluate SSA's fiscal controls aimed at assuring appropriate CE purchasing; and
- identify and provide information on operations of the major volume providers nationwide.

We specifically agreed with the Chairman's office that we would not attempt to

- measure the cause/effect relationship between CEs and final disability decisions,
- identify interlocking relationships between volume providers and medical laboratories that perform diagnostic tests used in providing CEs, or
- measure the overall quality of CE examinations or resulting reports.

We have not measured the effect of CEs on final disability determinations. Isolating the decisional impact of CEs from all other effects would be highly problematical and costly because of the complexity of the disability determination process. In addition to medical evidence, the process requires consideration of educational and vocational factors. Nor have we tried to identify interlocking relationships or independently measure the overall quality of examinations or resulting reports, because of the extensive resources required and the complex measurement issues involved in determining quality. (Instead, as indicated above, we agreed to evaluate SSA and state agency efforts to ensure quality and fiscal responsibility.)

In assessing management of the CE process, we focused on SSA initiatives implemented since the 1981 hearings, the degree to which these initiatives have been implemented, and their effectiveness in correcting the weaknesses identified during the hearings. Our review covered SSA and state agency activities from July 1982 to March 1985. We reviewed guidance and standards issued by SSA and interviewed headquarters personnel responsible for their development.

We visited all 10 SSA regional offices to determine how well they were guiding and monitoring state agency management of the CE process. There, we interviewed Disability Programs Branch and Disability Analysis Branch personnel and reviewed correspondence files, trip reports, and other CE-related documentation. We also visited central and regional offices of the HHS Inspector General to determine the Inspector General's role in reviewing fiscal controls over CE purchasing.

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To develop information about DDS CE management, we obtained CE management plans submitted by 52 state agencies between 1982 and 1985 and mailed the agencies questionnaires to determine

- the extent to which CE management plans had been implemented,
- how states monitored CE reports for quality,
- how they conducted on-site visits to volume providers, and
- the extent of their record keeping on the CE process.

In addition, we visited state agencies in California, New York, Texas, Ohio, Virginia, Indiana, and Kentucky. The first 4 states were selected because they were among the top 10 CE expenditure states with the largest volume provider populations; the others to provide better geographical distribution and information on less urbanized states. We interviewed DDS personnel responsible for all aspects of the agencies' CE management, including 47 managers and supervisors, 37 medical consultants, and 84 disability examiners. In addition, we reviewed CE provider files, appointment schedules, and payment vouchers.

To develop information on volume providers, we identified all providers with more than $100,000 in CE billings in fiscal year 1983, and mailed each a questionnaire about their methods of operation, perceptions about the CE process, and opinions on the adequacy of SSA guidance and standards. To elicit more detail, we visited the facilities of 11 volume providers in 7 states. We also reviewed SSA and state agency reports of visits to volume providers.

Although we did not attempt to measure the quality of CE reports, we reviewed the results of a 1983 SSA study comparing the quality of reports purchased from volume and nonvolume sources. We also obtained opinions about CE report quality from more than 200 people involved with the disability decision-making process. These included state agency personnel, SSA regional office personnel, administrative law judges, and legal aid representatives.

Our work was performed in accordance with generally accepted government auditing standards. The views of directly responsible officials were obtained and incorporated into the report where appropriate. In accordance with the requester's wishes, we did not ask HHS to review and comment officially on a draft of this report.

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Chapter 2

Concerns Over CE Process, Volume Providers Lead to SSA Management Initiatives

In the early 1980's, increasing use by DDSs of CEs in making disability determinations and of volume providers to supply CEs became the subject of congressional and public concern. Court actions and adverse media publicity raised questions about the operations of several volume providers, the validity of their examinations, and the reliability of their reports.

In response to congressional and public criticism, SSA in 1982 began efforts to improve CE management. This chapter discusses SSA's efforts to strengthen management of the CE process and progress to date.

Courts and the Congress Express Concern

In 1981, a series of lawsuits was filed in U.S. district court against the Secretary of Health and Human Services by disability claimants. They alleged improprieties in the examination and report preparation procedures of a volume provider performing CEs for seven states in three regions. In one case, a U.S. district court judge found that the provider's "reports, practices, medical procedures, methods and cursory examinations . . . are fraudulent in nature." In a subsequent related case, the court, reiterating its earlier finding, stated that "the practices and procedures in producing such Social Security consultative reports are deceptive and fraudulent." Testimony in the first case established that the physician would examine a claimant for a few minutes, dictate cursory notes, and send the information to another physician who had never seen the claimant. Subsequently, the latter physician, using word-processing equipment, would produce a report evaluating the claimant's physical capabilities and sign it in the examining physician's name.

Following the court's ruling, SSA suspended use of the provider. SSA investigated the allegations at the same time a Federal Bureau of Investigation (FBI) investigation into the matter was underway. After finding the services satisfactory, SSA reinstated the provider although requiring some minor changes in practices; the FBI found no evidence of criminal wrongdoing.

Another volume provider, operating in six states, came under congressional scrutiny following a television series on its operations. The provider, using mobile vans to cover large rural areas, performed as many as 65 examinations a day. The news reports questioned whether claimants received adequate examinations and whether medical findings were accurately reported. Again, SSA reviewed the provider's operations, found little substantive wrongdoing, and requested minor procedural changes.

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In September 1981 and again in March 1982, the Subcommittees on Social Security and Oversight of the House Committee on Ways and Means held hearings to assess the nature of the volume provider problem and ascertain the role and responsibility of SSA and the state agencies in supervising and monitoring provider operations. Claimants, legal representatives, and advocacy groups testified, claiming abuses and biases in examinations and reports by various volume providers in several areas of the country. The record shows the Congress' concern about the validity of examinations, the reliability of reports, and adequacy of SSA/DDS supervision of the process. SSA was criticized for not being knowledgeable enough about the CE and volume provider situation and not moving fast enough to improve CE management.

Condition of DDSs' CE Management Examined

Historically, under the federal/state relationship in the management of the disability programs, SSA has permitted states wide latitude in controlling and managing their CE resources. SSA has performed only a limited oversight role, publishing regulations, administrative guidelines, and adjudicative criteria, and setting out DDS responsibilities in obtaining existing medical evidence and purchasing CEs. The DDSs recruit, maintain, and control their CE resources. But SSA has had little information about the effectiveness of CE management by DDSs or the quality of services performed by volume providers.

In July 1981, the court actions and adverse media publicity prompted SSA to conduct a survey of DDS CE management practices. Each DDS was asked to describe, among other things, (1) the size and types of providers on its CE panel; (2) cost information to show the number of billing entities and the ranges and amounts paid to top providers; and (3) its procedures for selecting the CE source to be used in a case, for reviewing providers' performance, and for handling complaints.

States were employing a variety of CE management and monitoring systems with varying and limited effectiveness, the survey revealed. Many states were unable to provide requested information, particularly cost data. Most financial record keeping and reporting systems were manual and not organized to allow CE-specific data to be easily extracted. As of November 1981, SSA reported, 37 DDSs had not fully responded to the survey.

Analyzing the states' survey responses, we found that:

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- The most common CE source-selection criteria were the type of examination needed, the claimant's location, and the promptness of appointment time and submission of examination reports.
- Most states reviewed the first few reports submitted by new providers, but only about one-fifth of the states performed ongoing review of reports from existing panel members. Almost all states relied primarily on examiners and medical staff to identify deficient CEs during case processing.
- Only seven states (13 percent) could provide on a timely basis complete cost data concerning CE payments to all providers. Most states' accounting systems did not break out costs by provider.

At the September 1981 congressional hearings, an SSA Associate Commissioner testified that SSA had not

- required states to review the adequacy of providers' CE reports, facilities, or equipment, or to perform other oversight activities,
- established a "disciplined process" to obtain information on the effectiveness of states' CE management, or
- directed state or federal medical reviewers to specifically assess the adequacy of CE reports.

In December 1981, the Associate Commissioner wrote to SSA's regional commissioners:

"It is apparent that we are vulnerable with respect to the CE process, particularly where volume providers, block-time, and other bulk arrangements are in use and that we can no longer rely on various, multiple, and in many instances casual oversight arrangements by individual disability determination services (DDSs) to ensure integrity of decisions and correction of provider deficiencies. A multi-faceted approach to gain control of the problems is underway and will include the issuance, in the near future, of monitoring and oversight guidelines for use by the DDSs, regional offices, and central office." (Emphasis added)

SSA Initiative to Improve CE Management

SSA thereby committed itself to gain better control of the CE process and take a more active oversight role. The agency's first step was on-site review of some volume providers and DDS monitoring and oversight of them. Findings and experience from these early reviews gave SSA a foundation to develop national guidelines for CE oversight and other management initiatives, which ultimately bore fruit, as discussed below.

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Volume Providers Appraised: Few Problems Found

In each federal region, three major providers were selected for on-site reviews by joint state/federal teams in early 1982. Few substantive problems were found, according to a December 1982 SSA analysis of the reviews. SSA determined from the reviews that

- large providers seemed to be doing a good job, especially in some medically underserved areas where physicians were hard to obtain;
- overall, physician and staff qualifications appeared sufficient;
- equipment used was average to above average, state certifications had been met, appointment scheduling seemed reasonable, facilities appeared clean, and fees were appropriate;
- there were no deficiency trends or patterns that could be identified as unique to volume providers' operations; and
- a larger proportion of claimant complaints were occurring where providers operated in nontraditional settings (e.g., old residential houses or mobile vans) or where provider operations were purely diagnostic, as opposed to more typical treatment settings.

The public perception that nontraditional facilities do not provide the same quality of service as traditional operations was not supported by the on-site reviews, SSA concluded. But because volume providers generated more claimant complaints, SSA noted, special attention should be paid to them.

SSA Policy Directives and Administrative Guidelines Issued

Based on the review findings, SSA developed and issued several policy directives and guidelines covering CE management responsibilities, CE report content and signature requirements, and consulting physician qualification and independence. For its initiatives, SSA established five major objectives:

- Assurance of an adequate supply of quality medical evidence through improved liaison with and education of the medical community in general and CE panelists;
- Professional development of DDS staff to assure optimal development of medical evidence, correct selection of CE specialists, and avoidance of inappropriate or incorrect development of cases;
- Improvement of the credibility of the CE process by monitoring for consistency with generally accepted medical practice;
- Establishment of effective communications with claimant advocacy groups to provide an understanding of the CE process and the evaluative, nontreatment role it fills; and

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- Prevention of fiscal fraud/abuse or unethical, questionable, or irregular practices.

The states were assigned primary responsibility for achieving these objectives. To guide DDS management of the CE process, SSA in July 1982 issued Fiscal and Administrative Letter 184. It directed DDSs to develop CE management plans that included procedures for the following "critical elements":

- Orientation, training, and review of new CE providers;
- Scheduling procedures to attain a good distribution of examinations and prevent overscheduling;
- Ongoing review of CE reports to assure that report content requirements were met;
- Procedures for handling complaints to assure timely resolution of problems;
- Systematic on-site reviews of volume providers to maintain current information;
- Evaluation of claimants' reactions to volume providers; and
- Maintenance of records of CE provider credentials, annual payments per provider, and results of complaint investigations, on-site reviews, and evaluations of claimant reactions.

SSA set no specific standards for any of the critical elements to be included in the plans and did not specify how the states were to structure their management systems to meet the objectives. Instead, SSA assigned its regional offices lead responsibility for guiding plan development by states and overseeing states' overall CE management. Specifically, the regional offices were directed to

- evaluate and approve states' CE management plans and staffing requirements;
- conduct reviews of the DDSs to ensure that their plans were implemented and operational;
- conduct annual comprehensive reviews to evaluate states' CE management overall; and
- conduct special DDS reviews to monitor the completeness of record keeping, quality reviews of CE reports, and handling of CE complaints.

As with its directives to the states, SSA provided no specific instruction on how to implement these responsibilities; for example, it did not specify what constituted an acceptable plan nor the scope of comprehensive reviews.

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SSA regional offices were also directed to submit to SSA central office semiannual reports of DDS CE management activities, including the number and type of claimant complaints, the number of visits to volume providers, and any changes to the states' volume provider population.

Other CE Management Initiatives

To improve general program administration, SSA in 1982 began sponsoring annual DDS management forums. These conferences were designed to promote communication of management ideas and techniques among DDS administrators. CE management has been a frequent topic of discussion at the forums.

To monitor program administrative costs and provide a mechanism for their control, SSA in 1982 contracted with a public accounting firm to develop a "Cost Effectiveness Measurement System" (CEMS). By the end of fiscal year 1986, SSA expects, the CEMS system will give SSA ongoing information about the relative cost performance of the DDSs nationwide. This will include detailed data on the cost of purchased medical services, separated by medical procedure, case type, and body system. SSA intends to use this system to monitor national trends in case-development practices.

SSA also clarified its policy on physician conflict of interest. A 1983 GAO study[1] found that, because SSA policy did not prohibit SSA or DDS physicians from having financial interests in firms or organizations performing CEs, it did not protect against conflict of interest. In response to our recommendation, SSA surveyed all program staff physicians, resolved several conflicts of interest, and issued a directive prohibiting such financial relationships by staff physicians.

Progress Has Been Made

SSA's initiatives have yielded beneficial results. By issuing new policies and procedures, SSA has provided better direction on physician standards and CE report requirements and established more formal CE management and oversight. As a result, state agencies have increased their CE monitoring activities and developed CE management plans.

At the end of the first year under the new policy and procedures, SSA's regional offices reported that some "very positive" gains had been

[1]SSA Needs to Protect Against Possible Conflict of Interest in Its Disability Programs (GAO/HRD-83-65, June 10, 1983).

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made. They cited various examples of improved CE processes throughout the nation such as decreased claimant complaints, expanded DDS medical relations staff and activities, increased reviews of CE providers, and improved record keeping.

The results of our questionnaire survey for this report also indicate progress at the state level. All 52 state agencies (including the District of Columbia and Puerto Rico) have developed CE oversight plans. Most (38) reported that, as a result of developing and implementing the plans, their CE monitoring procedures had improved. Forty-one DDSs reported that they had procedures for obtaining claimant reactions; 44 said they had conducted annual on-site reviews of most of their volume providers. Payment records by providers were available, most DDSs reported; only four DDSs still did not maintain such records.[2]

Our visits to selected DDSs also confirmed that SSA's initiatives had raised states' awareness of the importance of CE oversight, and their level of CE monitoring. All states we visited had designated medical relations professionals to administer and coordinate CE activities. Some states had expanded their medical relations staff to enhance their CE management process. All were making on-site reviews of most volume providers. Our review indicated that states had increased their CE activities and attempted to comply with the new requirements. The following chapter discusses areas in which SSA and states could further improve the CE management process.

[2]As discussed on page 18, an SSA survey found only seven DDSs could provide such records in 1981.

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Chapter 3

Further Strengthening of CE Management Processes Needed

As discussed in the previous chapter, the 1981 and 1982 congressional hearings on consultative examinations revealed concerns about the CE process and SSA's and the states' management of it. Since 1981, SSA has taken steps to improve its overall handling of the process. These actions have heightened DDSs' awareness about the importance of good CE management as well as actually strengthened the process.

SSA, however, could further improve states' management of the CE process and better assure that quality medical examinations and reports are purchased by (1) establishing specific standards for certain important elements of DDSs' CE management systems (CE scheduling and report review) and (2) ensuring that SSA regional office oversight is effectively conducted nationwide.

Moreover, by establishing appropriate controls over the ordering of CEs, SSA could better realize its goal of preventing fiscal fraud and abuse of CE funds. Several studies conducted by SSA regional offices and DDSs have found significant rates of premature and inappropriate CE purchasing in several states. We believe SSA should determine if more physician involvement in CE ordering and establishment of controls over the timing of CE purchases are needed.

Details of these issues are discussed below, followed by our conclusions and recommendations resulting from our examination of the CE process.

CE Scheduling and Report Review by States: Specific Guidance Lacking

In its CE management initiative, SSA required DDSs to establish CE management plans and SSA regional offices to oversee state efforts. In its 1982 instructions to the states and regions establishing the objectives of its CE management program, SSA identified seven "critical elements" of the CE process to be included in state plans:

- Controls on appointment scheduling,
- Quality review of CE reports,
- On-site visits to key providers,[1]
- Claimant reaction surveys,
- Complaint resolution,
- Provider orientation, and
- Record keeping.

[1]In 1982, SSA replaced the term "volume provider" with "key provider," although these terms are still often used interchangeably. See appendix I for definition of key provider.

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Design of the CE management system, however, was left to state discretion. This appears consistent with SSA's historical approach of giving states wide latitude in managing their own operations.

SSA's efforts were intended to eliminate some of the vulnerabilities in the CE process identified in 1981 and 1982 and to improve public perception of the disability programs' integrity. In addition to identifying the critical management areas, SSA appropriately recognized its need to know how well DDSs perform in each area. But SSA's progress in improving management and oversight of the CE process has been limited. Not having established specific standards or guidelines for some plan elements, SSA cannot adequately measure DDS performance. This increases the disability programs' vulnerability to such problems as overscheduling of examinations and the purchase of poor quality CE reports. We discuss the scheduling and review problems below.

"Assembly-Line" Exams: A Major Concern

Standards are essential to performance measurement; they enable managers to compare how a program or process is functioning to how it should be functioning. Currently, SSA lacks adequate capability to measure states' performance in controlling CE scheduling because it has not set specific standards for this function.

The brief amount of time that some CE providers spent examining claimants was a major concern expressed during the 1981 and 1982 congressional hearings. Many people were troubled by the apparent "assembly-line" examination process used by some volume providers examining large numbers of claimants (up to 65 a day). Witnesses called on SSA to set reasonable standards governing the number of examinations to be performed by CE physicians on an hourly or daily basis. One of the largest volume providers in the country testified in favor of establishing standards and recommended minimum time standards for several types of examinations.

Following the hearings, SSA instructed the states to establish "scheduling controls to attain a good distribution of examinations among providers and to prevent overscheduling." These guidelines did not specify what constituted a good distribution of referrals or how to prevent overscheduling. As evidenced by early policy drafts, SSA initially considered issuing specific standards for examination scheduling, but finally issued

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general guidelines, apparently deciding to give states managerial flexibility.

Scheduling Standards Found to Vary Widely

We reviewed all state CE management plans and sent each DDS a questionnaire on its CE management efforts. Most plans did not adequately describe how CE appointment scheduling was controlled. Also, according to our questionnaire survey, 30 of the 52 DDSs had not established any scheduling standards. The standards states did have varied widely. Some limited the number of examinations that could be scheduled with individual physicians (ranging from one to three examinations per hour). Other states set specific standards for a minimum examination duration for certain medical specialties. Some DDS standards applied to all CEs, others only to certain providers or certain medical examinations. Our specific findings for the seven states we visited are presented below.

Two states we visited—California and Texas—lacked standards for the number of appointments scheduled per hour and did not track appointment time. State officials said they relied on providers' professional integrity and on such monitoring mechanisms as report reviews, on-site visits, and claimant reaction evaluations to detect problems. While the Texas DDS appeared to be adequately implementing these monitoring techniques, we found that the California DDS was not obtaining claimants' reactions and did not document their on-site visits or report reviews sufficiently to enable us to determine the effectiveness of their monitoring efforts.

The New York DDS also lacked appointment scheduling standards and did not track appointment time. Bulk referrals of claimants were made to the DDS' volume providers, which then contacted claimants and set appointment dates. This DDS did have, however, minimum examination duration standards (20 minutes for physical examinations, 30 for psychiatric examinations), developed in consultation with DDS medical staff. DDS officials told us they developed these standards to improve public perception of the CE process and monitor providers' performance. New York DDS staff timed and obtained claimants' estimates of the duration of examinations during on-site visits. Claimants' estimates of examination duration were also obtained in the DDS' survey of claimants' reactions to being examined by volume providers.

The other four states we visited—Ohio, Kentucky, Indiana, and Virginia—had standards governing the number of appointments that could

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be scheduled per hour with volume providers. Two (Kentucky and Indiana), however, did not follow their own standards. For example, at the Kentucky DDS, which had a standard of 20-minute intervals between appointments for internal medicine, orthopedic, and psychiatric examinations, we reviewed 6 months of scheduling records from 1983. The DDS was scheduling appointments with three volume CE sources (all individual practitioners) at intervals as short as 8 minutes for internal medicine examinations and 12 for psychiatric CEs. Even after adjusting for cancellations and "no-shows," the average time available for examinations was less than 20 minutes per claimant, assuming the physicians took no time for lunch or breaks.

Officials Differ on Need for Standards

In discussing the need for standards governing appointment scheduling and examination duration, some SSA and DDS officials expressed concerns over the difficulties in setting specific standards. Among the reasons they cited for not developing standards were:

- Variations in what was required as consultative evidence. Some disability claims called for comprehensive medical examinations, while others required more limited examination or diagnostic testing.
- Variations in examination techniques. Some providers utilized auxiliary personnel to obtain claimants' medical histories and perform basic diagnostic testing, while in other cases physicians performed these operations. Also, physicians, like other individuals, work at different rates of speed.
- Variations in claimants' responsiveness. Individuals differ in impairments, cooperativeness, and ability to respond to the examination process.

Program officials also contended that much of the negative public perception of the CE process resulted from a misunderstanding of the purpose of CEs, which are evaluative, not treatment-oriented, and thus often require less extensive medical development.

But other people involved with the disability programs we interviewed, including some SSA and DDS officials, believed that some standards should be established. Also, as noted earlier, numerous witnesses at the 1981 and 1982 congressional hearings, including a DDS administrator and one of the largest volume providers in the country, called for establishment of standards concerning reasonable scheduling and/or minimum examination duration.

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We recognize that valid arguments can be presented for both points of view. We believe, however, that the absence of scheduling standards at the state level impedes measurement of how states are performing in this area and causes inconsistency in states' scheduling practices.

Many claimant complaints received by the DDSs we visited concerned short duration of examinations. A number of legal aid attorneys and administrative law judges we interviewed, having heard frequent claimant complaints about brief examinations, expressed skepticism about volume providers' examination practices.

The Illinois DDS had recently adopted a policy requiring CE physicians to state in their reports the amount of time spent performing examinations. State officials told us that, while they believed their policy would make CE physicians more accountable, they would like to see SSA develop standards, without which they had difficulty monitoring and measuring providers' performance.

The Wisconsin DDS had established minimum examination duration standards of 20-30 minutes for physical examinations and 45-60 minutes for psychiatric examinations. The standards, which applied to all CE providers in these specialties, had been generally accepted by physicians recruited for the state's CE panel, DDS officials told us. They said they had received very few claimant complaints about short examination duration.

The heightened interest and concerns expressed about CEs occurred in 1981 and 1982 when states had large increases in workloads and numbers of CEs required. These were due to the massive number of reexaminations mandated by the 1980 Disability Amendments. But we conducted most of our work and discussions with program officials and others at a time when the numbers of cases processed and CEs purchased were sharply reduced. This resulted from widespread state moratoriums (and since April 1984, an SSA moratorium) on processing continuing disability reviews.

SSA plans to resume processing CDRs in fiscal year 1986; it projects that 504,200 CDRs will be processed in that year. These CDRs represent a significant part of the projected 26-percent increase in DDS workloads from 1984 to 1986. SSA projects a 29-percent increase in CE expenditures during the same period.

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Based on our evaluation of the states' CE management plans and our visits to seven DDSs, we believe that many state scheduling procedures do not provide reasonable assurance that the type of scheduling practices that caused much public controversy in 1981 and 1982 will not recur when DDS workloads increase again.

We agree with SSA's objective of enhancing the public's confidence in the disability programs. For claimants, being sent for CEs is often their main direct contact with the disability determination process. Claimants' perception of their CE experience is central to the programs' overall credibility. Examination duration was a major concern about the CE process and volume provider practices expressed in congressional testimony. Because it continues to be a central issue in the mind of many claimants and observers, we believe that SSA should, at a minimum, require states that use volume providers to establish standards for controlling appointment scheduling and/or examination duration. To prevent the type of controversy about volume provider examination practices that occurred during the initial implementation of CDRs, we believe it preferable that these standards be established before resuming CDRs or, if this is not possible, soon after.

Determining CE Quality: More Review Guidance Needed

The way that certain volume providers prepared reports of consultative examinations was another major concern expressed during the 1981 and 1982 hearings. Through the use of word processing equipment and "canned language," critics charged, volume providers generated reports to DDSs that were more extensive and comprehensive than the examinations they performed and that did not accurately represent claimants' medical conditions.

SSA had not directed state or federal medical reviewers to specifically assess the adequacy of CE reports, the agency testified. At the time, the report review process in most states consisted of examiners and medical consultants reviewing reports for adequacy and completeness as part of routine case development and decision making.

After the hearings, SSA issued guidelines establishing CE report content and format for various medical specialty examinations (neurological, orthopedic, etc.). SSA staff considered instructing states to use random sample selection procedures and involve medical consultants in conducting report reviews. Again, however, SSA opted to issue general guidelines, instructing states to establish procedures for reviewing new providers' reports and maintaining an "ongoing review of CE reports."

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SSA did not specify how the states were to structure their review systems (e.g., the method for selecting and evaluating reports) or designate who was to perform the function. The agency intended DDSs to establish report review systems separate from the routine adjudicative process, SSA central office staff told us.

While most states' CE management plans indicated that the first few reports submitted by new CE providers were reviewed by specially designated staff, such as medical relations officers or chief medical consultants, 32 of the 52 state plans indicated that the states continued to rely primarily on examiners and medical consultants to scrutinize CE reports as part of the case development process; this constituted "ongoing review." The remainder of the state plans indicated that the states had some other report review processes in addition to routine case-development report review.

Of the seven DDSs we visited, Texas' report review system appeared to provide the greatest reasonable assurance that deficient CE reports would be identified and corrective actions taken. The DDS had established a centralized report review staff with medically trained personnel that functioned outside the routine case-adjudication process. The review staff screened for deficiencies all reports of medical procedures determined by the DDS to have a high risk of deficiency—e.g., pulmonary function and blood gas studies and comprehensive psychological evaluations. With help from designated medical consultants, the staff also reviewed on a stratified sample basis reports submitted by all CE providers on the state's panel. About 25 percent of the CEs purchased by the DDS were subjected to review. Any provider of a report found significantly deficient would be immediately suspended from doing further CEs until that provider could be contacted and the problem corrected.

Two other states we visited, Kentucky and Ohio, also had separate report review systems, but their systems were not as effective as that employed by the Texas DDS. In Kentucky, medical relations staff reviewed for completeness the first 6 (4 percent) of the 140 reports the DDS received on average each day. In Ohio, quality assurance (QA) staff reviewed a random sample of 25 (3 percent) of the approximately 900 CE reports the DDS received in an average week. These two systems did not, however, target reports of medical procedures with high risks of deficiency for review or assure that reports from all providers were reviewed in such a manner that patterns of deficient performance by individual providers would be detected.

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The other states we visited (California, New York, Virginia, and Indiana) continued to rely on examiners and medical consultants to detect deficient CE reports during normal case adjudication. Based on our visits, we question whether report review systems that rely primarily on examiners to report deficient CEs to DDS management provide reasonable assurance that sources of deficient reports will be identified. Examiners in most of these states told us that case-processing time pressures inhibited their substantive review of CE reports and willingness to report deficient CEs to DDS management. Their principal concern, said many examiners, was making disability determinations, not assessing CE report quality. Examiners said they often chose to "live with" deficient CE reports as long as they contained usable evidence to support disability determinations.

Relying on examiners to report deficient CE reports during routine claim adjudication fails to assure that deficiency trends are identified. For example, if several different examiners receive deficient reports from the same CE source, each may assume that the deficiencies are isolated and not report them to DDS management for correction. While relying on examiners to assess reports and identify deficiency trends may be a reasonable method for states that have small staffs and CE panels,[2] we question whether deficiency trends would be identified and problems corrected in DDSs such as New York or California. The former had 400 examiners on staff and about 3,500 providers on its CE panel, the latter, 360 examiners and about 6,000 CE providers.

Sometimes examiners failed to report problems with CE reports, we learned. Examiners and medical consultants in the Indiana, Kentucky, and Ohio DDSs and the Oakland branch of the California DDS told us that they had stopped bringing deficient CE reports to management attention because of inaction on earlier referrals. They saw continuing problems with certain providers and certain medical procedures that were never adequately addressed, they said.

In response to our questionnaire survey, 43 states indicated that CE reports were reviewed during their QA review process. QA staff in four states we visited, however, told us their main function was to review case files in their entirety to see if they agreed with examiners' decisions to deny or allow claims. The QA staff did not specifically assess CE report quality as part of their routine QA process. (Kentucky lacked a QA unit at the time of our visit.)

[2]In 1984, 17 states had fewer than 25 examiners on their staff.

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Because of these weaknesses in CE report review systems that relied principally on adjudicative staff to review reports during routine case-processing, we believe that SSA should clarify its intent concerning ongoing report review in its instructions to the states. SSA should require the larger DDSs to establish an independent report review system, such as that employed by the Texas DDS.

Some Regional Office Oversight Inadequate

SSA's 10 regional offices guide, support, and monitor state CE management efforts. Specifically, SSA requires its regional offices to

- evaluate and approve states' CE management plans and ensure that they are implemented and operational and
- conduct annual comprehensive reviews and other special reviews as needed to evaluate states' CE management overall.

We visited all 10 SSA regional offices to assess their effectiveness in carrying out these responsibilities. Like the state DDSs, we found wide variance in regional oversight efforts. Some regions did not adequately review states' CE management plans; many deficient state plans were approved. Also, some regional offices had not reviewed states' implementation of their CE management plans nor conducted annual comprehensive reviews of their overall CE management, as required. Furthermore, most regions did not adequately monitor DDSs' ordering practices to assure the necessity and appropriateness of CE purchases.

Development of State Plans: Regional Oversight Varies

In 1982, SSA instructed its regional offices to help states develop their CE management plans, evaluate them for adequacy, and approve them. Most regional offices did not provide additional written instruction for development of CE management plans, we found. In most regions, the SSA staff told us, they considered SSA's general instructions to the states to be sufficient.

Of the 52 DDSs, 29 responded to our questionnaire survey that the regional offices accepted their CE management plans as submitted. In most SSA regions, the staff said they accepted any plan that addressed all seven critical management elements.

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Because of the federal/state relationship[3] in the disability programs, Chicago and Boston Regional Office disability staff told us, they could not "require" states to structure their CE management systems in any particular manner. If a state's plan reflected the "spirit" of SSA's guidelines, regional staff were satisfied. Simply having states submit CE management plans constituted a significant accomplishment, Denver Regional Office disability program staff said, considering the program's regulatory environment.

In reviewing all 52 CE management plans in effect in March 1985, we found wide variance in quality. Plan length ranged from less than 1 page to 18 pages plus attachments. Only 7 of the 52 plans indicated that the agencies had established specific procedures to meet all seven critical elements identified by SSA. Seven state plans omitted one element or more entirely. In our opinion, the majority of the plans lacked sufficient indication of how the objectives of all elements of the plan were to be achieved. In many cases, responsible personnel were not identified and the nature of implementing actions not described. For example, 30 plans did not clearly describe how the agencies' scheduling controls prevented overscheduling.

Implementing State Plans: Review Often Inadequate

In 1982, SSA instructed its regional offices to conduct reviews to ensure that state CE management plans were "implemented and operational" and to conduct annual comprehensive reviews to evaluate states' overall CE management. No specific direction on how these reviews were to be conducted was provided, nor was the scope of the comprehensive reviews defined.

Several regional offices had not reviewed plan implementation, we found, and most regional offices were not conducting reviews of states' overall CE management comprehensive enough to include fiscal controls over CE purchasing.

At the time of our visits in the spring and summer of 1984 (2 years after SSA issued its instructions), four regions were not conducting annual comprehensive reviews and had not conducted reviews of any of their states' plan implementation. Six regions were performing reviews they considered comprehensive, but which we found to be essentially plan-

[3]SSA regulations allow states maximum managerial flexibility if SSA's case-processing standards are met.

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implementation reviews. (One of these regions had conducted reviews in only some of its states.)

In several cases, these "comprehensive" reviews consisted of interviews of DDS staff—medical relations officers or DDS administrators—responsible for implementing the agencies' management plans, with no independent verification that formal procedures were being implemented.

One region, Dallas, was performing reviews of states' overall CE management that we considered reasonably comprehensive. Their reviews were performed on an 18-month cycle and in four parts, covering organization, staffing, and medical relations; workflow, evidence, and case controls; fiscal controls; and quality assurance. In addition to reviewing implementation of the CE management plan, the review addressed such other CE management-related considerations as

- the extent of medical consultant involvement in determining the need for CEs and the type to be purchased;
- DDS efforts to obtain medical evidence of record from claimants' treating sources; and
- fiscal controls over CE purchasing and payment.

As of the summer of 1984, many states were not implementing certain important provisions of their CE management plans, our visits and DDS responses to our questionnaire revealed. For example, SSA guidelines require states to conduct at least one on-site visit to each key (volume) provider annually and to obtain and evaluate claimants' reactions to being examined by key providers. SSA emphasized that early detection and timely resolution of problems would enhance public confidence in the CE process. Our questionnaire survey of the DDSs and volume providers indicated that these techniques were widely viewed as beneficial. However, we found that:

- On-site visits were not always done. Eight DDSs reported they had not visited any of their key providers, and 19 other DDSs had visited some but not all of their key providers as required by SSA. Of the 96 volume providers responding to our questionnaire survey, 6 reported they had not been visited by any DDS (the largest of these 6 had received about $600,000 in CE payments in fiscal year 1983). Twelve others said the states had visited only some of their facilities.
- Claimant reaction surveys were not being conducted by some states. Eleven DDSs reported no procedures for obtaining claimant reactions. Four of the seven states we visited did not routinely perform these

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surveys, even though two of the states' CE management plans indicated that they had procedures to implement this requirement.

Oversight of CE Purchasing: Improvement Needed

Where DDSs have met SSA's standards for decisional accuracy and case-processing time, regional office oversight of fiscal controls over CE purchasing has been minimal. Except for DDSs that fail to meet the performance standards,[4] DDS internal control reviews are the responsibility of HHS Office of Inspector General (OIG) audit staff, SSA regional officials said.

But OIG oversight of DDSs' CE purchasing has been minimal, we found. Since the mid-1970's, OIG officials told us, DDS audits contracted by OIG and those performed by states under the Office of Management and Budget's Circular A-102, Attachment P (which assigned to states the primary responsibility for conducting audits of federal funds granted to states),[5] have considered mainly the accuracy of financial reporting and have not specifically considered CE-ordering practices. Reviewing a sample of 29 reports of DDS audits performed since 1980 by both federal contractors and the states, we found none that considered such programmatic issues as the necessity and appropriateness of CE purchases.

We believe the lack of systematic regional office oversight of DDS CE management, especially of controls over CE purchasing, increases the risk of unnecessary CE purchasing.

Too Many CEs? Study of Purchasing Needed

As SSA expenditures on consultative examinations represent a significant proportion of the disability programs' administrative budget, preventing unnecessary CE purchasing could have a large impact on that budget. For example, SSA budgeted $203 million for CEs in fiscal year 1986; each percentage point reduction in expenditures for unnecessary CEs would save $2 million.

We found evidence of unnecessary CE purchases by several DDSs in recent years. Several studies conducted by SSA regional office and DDS

[4]Before the 1980 Disability Amendments, SSA staff routinely conducted Fiscal and Administrative Management Reviews (FAMRs)—comprehensive reviews of DDS operations. Since the amendments, FAMRs are required to be conducted only in states that fail to meet SSA performance standards. Between 1981 and mid-1985, FAMRs were conducted in 12 states.

[5]Between the mid-1970s and early 1980s, the OIG contracted with public accounting firms to conduct most DDS audits. These were generally financial compliance audits that did not consider programmatic issues such as the necessity or appropriateness of CE purchases.

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staff recorded significant rates of premature, inappropriate CE purchases in four states between 1981 and 1984. We believe there is a potential for similar problems in other states, based on our discussions with SSA and DDS officials.

Because of this potential, SSA needs to examine several aspects of the CE ordering process. SSA, which now has draft regulations on the development of medical evidence, should closely monitor states' implementation of its new requirements to learn if DDSs are purchasing CEs appropriately. As physician involvement in reviewing and approving requests for CEs varies from state to state, a study is needed to determine if more physician involvement is warranted.

Evidence of Unnecessary Purchases Found

To learn if any recent studies of the appropriateness of CE purchases had been conducted, we surveyed all SSA regions and DDSs. SSA regional office and DDS staff conducted six studies in four states between 1981 and 1984. All the studies noted high rates of premature and inappropriate CE purchasing. They found deficiencies in examiners' efforts to obtain treating source records, and CE purchases that were inappropriate in terms of program evidentiary requirements. Between 13 and 43 percent of CEs purchased were premature and/or inappropriate, the studies found (see table 3.1).

In addition to the unnecessary examinations, two studies found high rates of unnecessary supplemental laboratory diagnostic procedures. The New Jersey DDS 1981 study found that 74 percent of the cases with supplemental procedures contained at least one unnecessary test. The Arizona DDS 1984 study found that 46 percent of tests and 60 percent of X-rays purchased were unnecessary.

We reviewed the studies' methodologies and interviewed program personnel who conducted them. The studies, we found, were reasonably well designed for sample selection and criteria for assessing the timing and appropriateness of CE purchases. Although the studies were conducted retrospectively, involved individual judgments about the sufficiency of evidence, and cannot be projected nationwide, we believe they provide a reasonably valid and consistent indication of a vulnerability in the CE purchase process.

Of the studies cited, only the Arizona study estimated the cost of unnecessary CE purchases. It found the DDS was spending an average of $42 a case on unnecessary CEs. After the study, the DDS held examiner training

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sessions and implemented such changes as generally restricting the simultaneous purchase of more than one CE for each claimant and postponing X-ray and laboratory work for most cases until physical examination reports were received. A follow-up study found that the state's CE purchase rate had dropped from 43.5 percent to 37.4 percent of claims processed, and the average total cost per case decreased 34 percent, from $220.37 to $146.54. The DDS estimated savings of about $500,000 during the first 6 months of fiscal year 1984, a sum equal to about 15 percent of its total CE budget in that year.

Table 3.1: Appropriateness of CE Purchases: Summary Results of SSA and DDS Studies

State DDS	Study year	Percent premature CEs[a]	Percent inappropriate CEs[b]	Total percent premature and inappropriate CEs
Arizona	1983	[c]	13	13
Delaware	1984	17[d]	8	25
New Jersey	1981	23	20	43
	1983	10	23	33
New York	1982	13	15	28
	1984	28	12	30

[a]CE purchases where examiners did not contact or did not make any follow-up contact(s) to obtain evidence apparently available from claimants' treating sources. (Note: While CEs purchased prematurely may have been useful in making determinations, they might not have been needed had treating source evidence been obtained.)

[b]CE purchases where (1) evidence from treating sources was timely and adequate to support a disability determination, (2) the wrong type of CE was purchased, (3) SSA instructions precluded CE purchase, or (4) a CE was not the proper vehicle to resolve outstanding issues.

[c]The Arizona study considered only whether CE purchases were necessary, not whether they were ordered prematurely. They considered a CE unnecessary if it did not make any difference to the final determination.

[d]The Delaware study found that about 38 percent of the study CEs were ordered immediately upon case receipt and concluded that more than half of these should have been ordered later.

SSA has conducted no special studies to assess the necessity or appropriateness of CE purchases nationwide. Unnecessary CEs are supposed to be recorded during SSA's QA review of states' performance.[6] This "technical case development error" is rarely cited, however. In one region, only three unnecessary CEs were coded over 2-1/2 years. Less than 1 percent of CEs were unnecessarily purchased in fiscal year 1984, SSA's nationwide statistics indicate. SSA officials acknowledged that their statistics

[6]As discussed on page 8, SSA regulations establish decisional accuracy standards that DDSs are supposed to meet. To measure states' performance, SSA's regional offices routinely perform quality assurance (QA) reviews of stratified samples of disability determinations.

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do not accurately represent the extent of unnecessary CE purchasing. This error is coded infrequently, they said, because judgment concerning the sufficiency of medical evidence is somewhat subjective and many case files lack records of chronological case-development actions. The latter precludes assessing the adequacy of examiners' efforts to obtain treating source records.

The findings of the six regional and state studies cited could not be projected nationally, as DDS operations vary widely. We therefore discussed with SSA officials the need for a national study to determine how large a problem unnecessary CE purchasing may be. Officials of SSA's Office of Disability agreed with us on the need for a special study and said they would incorporate a study of the necessity of CE purchasing in their plan to evaluate (in fiscal year 1986) the effect of the Disability Benefits Reform Act of 1984. Also, when SSA's Cost Effectiveness Measurement System (CEMS) is fully implemented in fiscal year 1986, they said, SSA will be able to better monitor DDS medical development costs and identify inappropriate CE purchase practices.

Optimal Timing Needed for CE Purchases

CEs should be purchased only when sufficient evidence of impairment is unavailable from claimants' treating sources and CEs should not be routinely purchased, SSA guidelines stipulate. While SSA requires that claimants' treating sources be contacted for evidence in most cases, it has not established a minimum period examiners must wait to receive treating source records before ordering CEs. It would be difficult to establish a uniform waiting period, SSA officials said, because the time needed varies widely depending on the type of evidence requested and the availability and responsiveness of claimants' treating sources.

Some states, however, have established their own minimum waiting periods for treating source evidence. According to our questionnaire survey, 21 DDSs have established minimum waits ranging from 10 to 30 days after examiners' case receipt, with the most common being 21 days.

During the course of our work, we heard comments from many SSA and DDS officials that SSA's standards for case-processing time may cause unnecessary CE purchasing because they make examiners reluctant to wait for the receipt of treating source evidence before ordering CEs. Some states "buy" case-processing time, many SSA officials told us, by ordering CEs immediately upon receipt of claims. This serves as a protection against having to order and wait for the CEs when adequate treating

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source evidence is not received in a timely manner. Examiners' performance is often rated according to decisional accuracy and speed of case processing, and many states' merit pay plans encourage speedy case processing.

Inadequate efforts by examiners to pursue medical evidence from treating sources has been a longstanding problem. Pressure to meet processing-time goals has caused some DDSs to adopt expedient practices in case development, such as ordering CEs without making reasonable efforts to obtain medical evidence of records,[7] we found from previous reports and congressional testimony.

To assure better development of medical evidence, the Disability Benefits Reform Act of 1984 requires that SSA issue regulations to establish standards for the purchase of CEs.[8] They also require that SSA make "every reasonable effort" to obtain treating source records and develop a complete medical history covering at least the 12 months preceding any determination that an individual is not disabled.

SSA is revising its case-processing time standards and issuing new regulations and program instructions to implement the provisions of the new law. In its proposed regulations, SSA defines "every reasonable effort" as an initial contact with every treating source and a follow-up contact after 10 days with all nonresponding sources. SSA also will require that examiners wait 20 days after follow-up contact with treating sources before using consultative evidence in making determinations.

While SSA's proposed regulations require that examiners wait 30 days for treating source evidence before using consultative evidence in making determinations, they do not prevent DDSs from purchasing CEs (having CE reports in hand) before the end of the waiting period for treating source evidence. Thus, the potential still exists for DDSs to purchase CEs that could be made unnecessary by the timely (within the 30-day waiting period) receipt of adequate treating source evidence.

[7]Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability (GAO/HRD-79-19, Oct. 9, 1979); testimony before the Senate Special Committee on Aging on SSA's Program for Reviewing the Disability of Persons With Mental Impairments (Apr. 7, 1983); and testimony before the Subcommittee on Social Security, House Committee on Ways and Means on SSA's Program for Reviewing the Continuing Eligibility of Disabled Persons (June 30, 1983).

[8]As of November 1985, SSA had not issued final CE regulations. The standards for CEs included in SSA's proposed regulations are substantively the same as those instructions contained in current operating manuals.

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We believe SSA should closely monitor the implementation of its new requirements to pursue treating source evidence to determine if DDSs are purchasing CEs prematurely. If SSA finds they are, it should change its regulations (now in draft) to require specifically that CE appointments be set at a time no earlier than the end of the proposed 30-day treating source evidence waiting period.[9] Such a change would allow sufficient time to obtain treating source evidence and cancel CEs if adequate evidence is received and in many cases could result in more appropriate purchases of examinations and supplemental tests.

Study of Physician Involvement in CE Ordering Needed

SSA guidelines state that controls should be established to assure that only needed examinations and tests are purchased and that medical consultant or supervisory approval of examiners' CE purchase requests should be "encouraged."

In the states we visited, the extent of supervisory and medical consultant review of examiners' CE purchase requests varied. In Kentucky, examiners' CE requests were not reviewed by supervisors or DDS staff physicians. In New York, only requests from new examiners or for certain high cost tests were reviewed by supervisors. These practices violate a generally accepted internal control principle—supervision is needed to ensure that appropriate transactions are made.

In Indiana, Virginia, and Texas, supervisors approved most CE requests, but only requests for examinations that posed a potential health risk to claimants (such as treadmill exercise tests) were reviewed by DDS staff physicians. The Ohio and California DDSs required staff physician approval of all CE requests.

The effect of staff physician review on the necessity and appropriateness of CE purchases is unclear. Some DDS officials we interviewed said that, because modern medical practice commonly involves over-ordering of tests as a protection against possible malpractice suits, requiring staff physicians to review all CE ordering would result in increased purchases of diagnostic tests. Many DDS staff physicians we interviewed, however, said that requiring their review of examiners' CE requests would substantially reduce unnecessary and inappropriate CE purchases. Program physicians can be trained, they said, to differentiate the evidentiary purpose of a CE versus the treatment needs of a patient.

[9]We recognize that there are situations where treating sources are unavailable, unresponsive, or unreliable. Thus, SSA may want to allow certain exceptions to the requirement.

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We did not independently evaluate the effect of medical staff review of CE requests on the necessity or appropriateness of CE purchases. Given the inconsistency in states' CE request-review practices and evidence of premature and inappropriate CE purchases, however (see table 3.1), we believe SSA should conduct a study of the effect of medical staff review of CE requests on the appropriateness of CE purchases. If found beneficial, SSA should require such review for all DDSs.

Conclusions

Compared with the state of CE management in 1981, we believe SSA has made progress in providing program direction and improving overall CE management. SSA's efforts to date have created a good basis on which to build public confidence and improve the programs' credibility. However, we found several areas in which SSA could further reduce its vulnerability to adverse public perception and improve its fiscal control over CE resources.

Specifically, we found that SSA has failed to provide clear guidance on the CE process. This and regional office variations in overseeing that process have resulted in a situation in which SSA cannot be reasonably assured that CE funds are appropriately expended and that the types of problems which caused much congressional and public concern in the early 1980's will not recur.

Recommendations

Accordingly, we recommend that the Secretary of HHS direct the Commissioner of SSA to:

1. Require states that use volume providers to establish standards for controlling CE appointment scheduling and/or examination duration. It is preferable that these standards be established before the resumption of continuing disability reviews.

2. Clarify SSA's intent and provide specific direction to states on structuring systems for ongoing review of CE reports and require the larger DDSs to establish independent report review systems.

3. Issue specific direction to SSA regional offices on how to conduct reviews of states' CE management plans and require them to reevaluate the plans to ensure that they have effective procedures for implementing each critical area of the CE process.

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4. Issue a comprehensive review guide to SSA regional offices for use in conducting annual and uniform comprehensive reviews of states' CE management activities.

5. Monitor DDSs' implementation of the new requirements to pursue treating source evidence to determine if additional controls (e.g., requiring CE appointments to be set at a time no earlier than the end of the proposed 30-day waiting period for treating source evidence) are needed to prevent premature and unnecessary CE purchasing.

6. Conduct a study to determine the effect of physician review of CE requests on the appropriateness of CE purchases and, if warranted, require that such reviews be mandatory for all DDSs.

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Appendix I

Volume Providers: Who They Are and How They Operate

About half of the states use volume providers, which play an important role in the consultative examination process. While only 108 of the 39,000 CE providers nationwide in fiscal year 1983 met our volume provider definition (receiving more than $100,000 for performing CEs), they were paid 22 percent of the $175 million spent on CEs that year.

Although "volume provider" is used in a generic sense, their characteristics vary widely. Despite their important role and continuing interest in them, relatively little information about their operating characteristics has been available. As noted in chapter 2, in 1982, SSA conducted on-site visits to obtain information about 30 selected volume providers. Since then, SSA has relied mainly on the states to monitor volume provider performance; it does not obtain on a continuing basis information about their operating characteristics or performance.

This appendix presents the results of our efforts to develop information about the national population of volume providers—who they are, how they operate, and (from the state agencies' perspective) the advantages and disadvantages of using them.

Defining Volume Provider Causes Confusion

"Volume provider" and "key provider" have been used by SSA and others to describe medical sources that perform a large number of CEs. The terms have been used interchangeably, although SSA defines them differently. In early 1982, SSA defined "volume provider" as any provider receiving either $100,000 or 10 percent of the DDS's annual CE expenditures in a given fiscal year. Later, SSA broadened the definition and introduced a new term—"key provider." SSA considers any CE provider that meets at least one of the following conditions a key provider:

1. Provider with estimated annual billings to the social security disability programs of $100,000 or more;

2. Provider or facility where the practice of medicine is primarily directed toward evaluative examinations rather than treatment of patients;

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3. Provider that performs CEs on an arrangement of block time[1] or agrees to perform a given number of examinations in a specified period of time; or

4. Provider that does not meet the above criteria, but is one of the top five CE providers, by dollar volume, in the state as evidenced by prior-year data.

The "key provider" definition caused some confusion and administrative problems. Some DDSs complained that they would have to do on-site visits of many small providers that may perform only a few examinations a month under block-time arrangements.[2] In February 1984, SSA instructed states to use a "common sense approach" in determining their key provider populations. SSA plans to refine its key provider definition and incorporate the changes in its new CE regulations.[3] As of November 1985, SSA had not issued final CE regulations.

Because of the problems associated with SSA's key provider definition and because we were interested in the largest CE providers nationwide, we defined "volume provider" as any provider that had received a total of $100,000 or more (from one or several state agencies combined) for performing CEs in fiscal or calendar year 1983. Thus, "volume providers" as we defined them, are a subgroup of SSA's key providers.

Volume Providers Characterized

To determine the national population of volume providers, we sent a questionnaire to 52 state agencies (including the District of Columbia and Puerto Rico DDSs) and asked them to identify all their CE providers that met our definition. Seven states were unable to provide actual payment data, so we asked for estimated payments. We then mailed a questionnaire to all potential volume providers to confirm the information provided by the DDSs and obtain detailed information about their mode of operation and perspectives on the CE process.

[1]Block-time arrangement refers to situations where a provider sets aside a block of time to do CEs for state agencies. This arrangement could be with or without agreement on the number of exams to be scheduled within the given time.

[2]As discussed in chapter 3, SSA requires DDSs to conduct on-site visits to key providers at least once a year.

[3]The Disability Benefits Reform Act of 1984 required SSA to prescribe regulations covering standards for deciding when and what type of CEs should be obtained and procedures for monitoring the CE process.

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About half (27) of the states reported that they used volume providers in 1983. Based on DDS responses and questionnaire confirmation from volume providers themselves, we determined that there were 108 volume providers nationwide in fiscal year 1983.

The operating characteristics of volume providers varied widely. Some were set up exclusively to do evaluative examinations and/or to perform CEs for SSA; some were hospitals; and others were conventional medical clinics.

Many of the larger providers were group practices having several offices in one or more states. Some staffed their offices with local part-time physicians; others established their own physician panel and had the physicians travel to various locations to see claimants. There were also individual practitioners who did not employ any other physicians besides themselves to perform CEs. Some of these providers traveled extensively among several offices in one or more states to see claimants.

Annual Income From CEs Surveyed

To develop information on volume providers' CE income, we asked the states to report the total CE payments made to each volume provider in fiscal year 1983. Seven states were unable to report the actual payments made to 32 volume providers. At our request, they provided estimated payments. Based on the data available, using estimates where necessary, volume providers can be categorized by their annual receipts of CE funds as shown in table I.1.

Volume providers' average CE income in fiscal year 1983 was $348,672; 61 percent received less than $250,000 in CE reimbursements. Nationwide, six volume providers were paid over $1 million, the largest provider receiving approximately $3 million.

The amounts shown in table I.1 represent the gross amounts paid the providers; they do not represent what individual owners or physicians earned. Many providers had several offices and employed other physicians and auxiliary medical personnel. In addition, payments for laboratory fees were often made to providers who in turn reimbursed other independent laboratory companies.

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Table I.1: Volume Providers' Annual CE Income (Fiscal Year 1983)

Range of annual CE income	Providers		Total amount paid	Average income
	Number	Percent		
$100,000-250,000	66	61.1	$ 9,598,605	$ 145,433
250,001-500,000	19	17.6	6,338,319	333,596
500,001-750,000	12	11.1	7,384,790	615,399
750,001-1,000,000	5	4.6	4,483,207	896,641
Over 1,000,000	6	5.6	9,851,634	1,641,939
Total	**108**	**100.0**	**$37,656,555**	**$ 348,672**

Similarly, the amounts shown do not necessarily represent the providers' gross income. Many volume providers derived income for both evaluation and treatment from a variety of sources—various city, county, and state agencies, federal agencies, insurance companies, and other private sources. Of the 88 questionnaire respondents[4] that provided income information, 73 (83 percent) largely or exclusively performed evaluative examinations (as distinguished from providing treatment or therapy). Of the 73 providers that largely or exclusively performed evaluative examinations, 57 (78 percent) reportedly received over 50 percent of their 1983 income from performing CEs for the social security disability programs; 12 (16 percent) received all their 1983 income from this source.

Providers' Market Share Varies

States' use of volume providers varied widely. Of the 27 states using volume providers in fiscal year 1983, most (17) reported that 25 percent or less of their CE expenditures were paid to volume providers. Five states paid between 25 and 50 percent of their CE expenditures to volume providers, and two— Illinois and New York—reported that between 70 and 90 percent of their 1983 CE expenditures went to volume providers. Three states did not know what percentage of their CE budgets was paid to volume providers.

Nationwide, states' use of volume providers has not significantly changed over the 3-year period between 1981 and 1983: 6 states increased their use, 10 decreased their use, and 10 reported no change in use of volume providers.

[4]We sent questionnaires to 108 providers that we determined to have received $100,000 or more in CE payments in fiscal year 1983. We received no responses from 12 volume providers; 8 others declined to provide income information.

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Reporting the most volume providers were California, 16; New York, 14; and Michigan and Tennessee, each 9. Alabama, Arizona, Kansas, Maryland, and the District of Columbia each reported one volume provider.

Volume providers constituted only a small proportion of CE providers. Nationwide, states reported having about 39,000 providers on their CE panels in 1983. The 27 states that used volume providers reported a total of 24,998 active CE providers. Volume providers constituted less than one half of 1 percent of the total number of panelists available to perform CEs in those states.

Despite their small population and the fact that nearly half the states did not use them, volume providers as a group received $38 million or 22 percent of the $175 million expended on CEs nationwide in fiscal year 1983. In the 27 states that used them, about 26 percent of 1983 CE expenditures were paid to volume providers.

Office Distribution, Facility Type Examined

While some volume providers had only one office, others had several offices located in one or more states. Based on questionnaire responses from 96 volume providers, we found that the vast majority of volume providers—90 percent—operated in a single state (see table I.2). On average, multioffice/ multistate providers were usually among the largest providers in the country; they employed more physicians and received greater amounts of CE funds than the other two groups. The largest nationwide was a multioffice/multistate provider based in Chicago, Illinois, that employed 49 physicians in eight different medical specialties and had five office locations in three states. This provider was also one of the fastest growing CE providers in the country, expanding from performing CEs for one state in 1981 to three states in 1983 and increasing its CE revenues from approximately $800,000 in 1981 to about $3 million in 1983.

Table I.2: Volume Providers' Office Distribution, Physician Staffing, and Income (Fiscal Year 1983)

	Number of providers	Average number of physicians employed	Average CE income per provider
Single office	52	5	$189,251
Multioffices in single state	34	10	489,360
Multioffices in multistates	10	20	853,921
Total	**96**	**8**	**$364,776**

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The type of facilities used by volume providers was the subject of concerns expressed during the 1981 and 1982 congressional hearings. Witnesses questioned the propriety of some volume providers' use of mobile vans and "traveling physicians" to perform CEs. SSA investigations in 1982 indicated that public perception of providers who used nontraditional facilities was poor and that such facilities generated a higher volume of complaints.

While a small number of volume providers still used nontraditional facilities, we found that in fiscal year 1983 most used such traditional medical facilities as medical offices and clinics (see table I.3). Nine providers used a total of 19 nontraditional facilities. Most nontraditional facilities were used by providers who performed psychological examinations only. Three providers used mobile vans to house X-ray and other medical equipment and transport them to other medical facilities to conduct examinations.

Table I.3: Volume Providers' Distribution by Facility Type (Fiscal Year 1983)

	Number of	Facility	
Traditional medical facilities	**providers**	**Number**	**Percent**
Hospital	6	9	3.9
Medical center/clinic	70	140	60.8
Other medical office	31	62	27.0
Subtotal	**107**	**211**	**91.7**
Nontraditional facilities			
Federal/state county offices	4	8	3.5
Mobile vans	3	5	2.2
Other (church, state park resort, hotel/motel, house, National Guard armory)	2	6	2.6
Subtotal	**9**	**19**	**8.3**
Total	**116[a]**	**230**	**100.0**

[a]As some providers used more than one type of facility and were counted more than once, the total number of providers exceeds the actual number of providers on our list.

One volume provider used five different nontraditional facilities, including hotels/motels, a state park resort, and a church to perform psychological CEs for the Kentucky DDS. The provider performed CEs in areas of Appalachia where, he told us, modern health care facilities were either nonexistent or overloaded. The claimants he served were usually more comfortable with a nontraditional environment, he explained, because they often had limited experience with traditional medical facilities. Kentucky DDS officials told us that they had visited the facilities and

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found them to be working well for psychological examinations in the area served. No complaints had been received from claimants, who were advised about the facilities beforehand.

During the course of our work, we visited 11 volume providers—4 multistate and 7 single-state. Generally, our visits were intended to gain a better understanding of provider operations and to obtain providers' perspectives concerning their interaction with state agencies and views on various aspects of the CE process and the disability programs. We did not inspect the facilities to assess their adequacy. All but one of the providers we visited operated in traditional medical facilities; we visited one who used a mobile van to transport diagnostic equipment to various locations. The offices we visited were clean and typical medical facilities.

Role of Volume Providers Debated

The role of volume providers in the disability programs is still a subject of debate. Critics often refer to them as "disability mills," suggesting that they render "assembly line, profit-driven" medical services. The validity of examinations performed by volume providers and the reliability of their reports are questioned. Advocates of volume providers believe they provide a vital service to DDSs and claimants, especially in medically underserved areas. They also claim that volume providers are better sources of evaluative examinations because they specialize in that field.

The DDSs also reported certain advantages and disadvantages of using volume providers. Overall, 21 of the 27 states that used them reported that advantages outweighed disadvantages. A discussion on the states' perspective follows.

Administrative Convenience, Other Advantages Cited

Volume providers are seen by states as offering a number of advantages. Most frequently the DDSs mentioned that volume providers

- were easier to schedule appointments with and often reduced DDSs' administrative burdens;
- provided more timely services, including earlier appointments and better report turnaround time; and
- had better knowledge of program requirements, thus providing better quality reports.

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Administrative convenience was one of the main reasons that DDSs often preferred volume sources. Many volume providers offered administrative assistance, such as contacting claimants to schedule appointments and making preexamination reminder calls to claimants. Scheduling appointments with volume providers was easier than with nonvolume sources, whose private practice was often their principal concern. Scheduling a number of examinations with a volume provider in one contact was also easier than making contact with a number of individual nonvolume sources. Many volume providers performed a wide range of specialty examinations and tests, which minimized the need to send claimants to various sources for different aspects of a CE (i.e., to a radiologist for an X-ray, a testing laboratory for a blood test, etc.) or for multiple CEs (e.g., internal medicine and psychological evaluation were performed at one location).

The timeliness with which volume providers scheduled appointments and returned reports was another significant reason for their use. As discussed earlier in this report (see p. 8), SSA measures states' performance on two parameters—accuracy of determinations and speed with which they are made. DDS officials stated that volume providers typically make appointments within short time frames, while appointments with nonvolume sources must be made in some cases up to a month or more in advance. Furthermore, volume providers were said to submit reports sooner after examination than nonvolume sources. We found this to be generally true upon reviewing a random sample of CE payment vouchers in three of the states we visited.

Volume providers' familiarity with SSA's CE report content requirements was said to result in more "usable" reports. Officials in 19 of the 27 states that used volume providers said that volume providers' report quality was better than nonvolume sources; officials in the 8 other states reported no overall difference.

In 1983, SSA conducted two studies of CE report quality to compare volume and nonvolume provider performance. The studies evaluated CE reports for completeness, consistency with evidence from other sources, and technical adequacy. CE reports from volume providers contained fewer deficiencies relative to program evidentiary requirements. In both studies, about 8 percent of volume provider reports contained deficiencies, while reports from nonvolume sources had a 12-percent deficiency rate in one study and about 17 percent in the other. There was considerable variation in deficiency rates from state to state and among category

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of impairments. Less than 1 percent of CEs studied, however, were found to be unacceptable (e.g., contained no usable evidence).

Instead of independently assessing CE report quality, we surveyed various SSA and DDS personnel for their opinions. We interviewed a total of 268 individuals (47 DDS managers and supervisors, 84 disability examiners, 37 DDS medical consultants, 74 SSA regional disability programs and QA staff, and 26 administrative law judges). The majority (88 percent) of those interviewed said that volume providers report quality was as good as, or better than, that of nonvolume sources.

Many of our interviewees, however, noted that CE report quality is not the same as examination quality. A good report does not necessarily reflect a good examination. Volume provider reports were better than those from nonvolume providers, many interviewees said. This was not necessarily because the former performed better examinations, but because they were familiar with SSA's report content requirements and produced reports better tailored to the programs' needs.

Examination quality is difficult to measure, however. SSA has not conducted studies in this area, and no other data were readily available to us to further analyze this question.

Some Disadvantages Seen

The states that used volume providers also reported some disadvantages to their use; most often cited (by 17 of the 27 states using such providers) was adverse public perception.

State agencies' concerns were supported by testimony received from sources both external and internal to the disability program administration. A number of legal aid attorneys and administrative law judges we interviewed expressed skepticism about volume providers' examination practices because they heard frequent claimant complaints about short examination duration. Some DDS medical consultants and supervisors also said that, while volume providers' reports were of better quality (more complete and usable), they often doubted the validity of some of the reports, which looked alike and appeared to contain "canned language." Five states (Colorado, Nevada, Massachusetts, Nebraska, and South Carolina) apparently were so concerned about public perception problems that their policy was not to use volume providers.

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Another reported disadvantage to volume provider utilization was the potential for overreliance on these sources. Several problems are inherent. A DDS might find itself in a dependent relationship and, should the volume provider's services be withdrawn, either voluntarily or involuntarily, the DDS' ability to process cases could be impaired. For example, in 1981, the Virginia DDS obtained about 34 percent of its CEs from volume providers. Because of a court case and other problems, two volume providers stopped performing CEs. The DDS later fell below SSA's standard for acceptable case-processing time. State officials told us it took them 2 years to recruit a sufficient number of providers to compensate for the loss of these two sources.

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